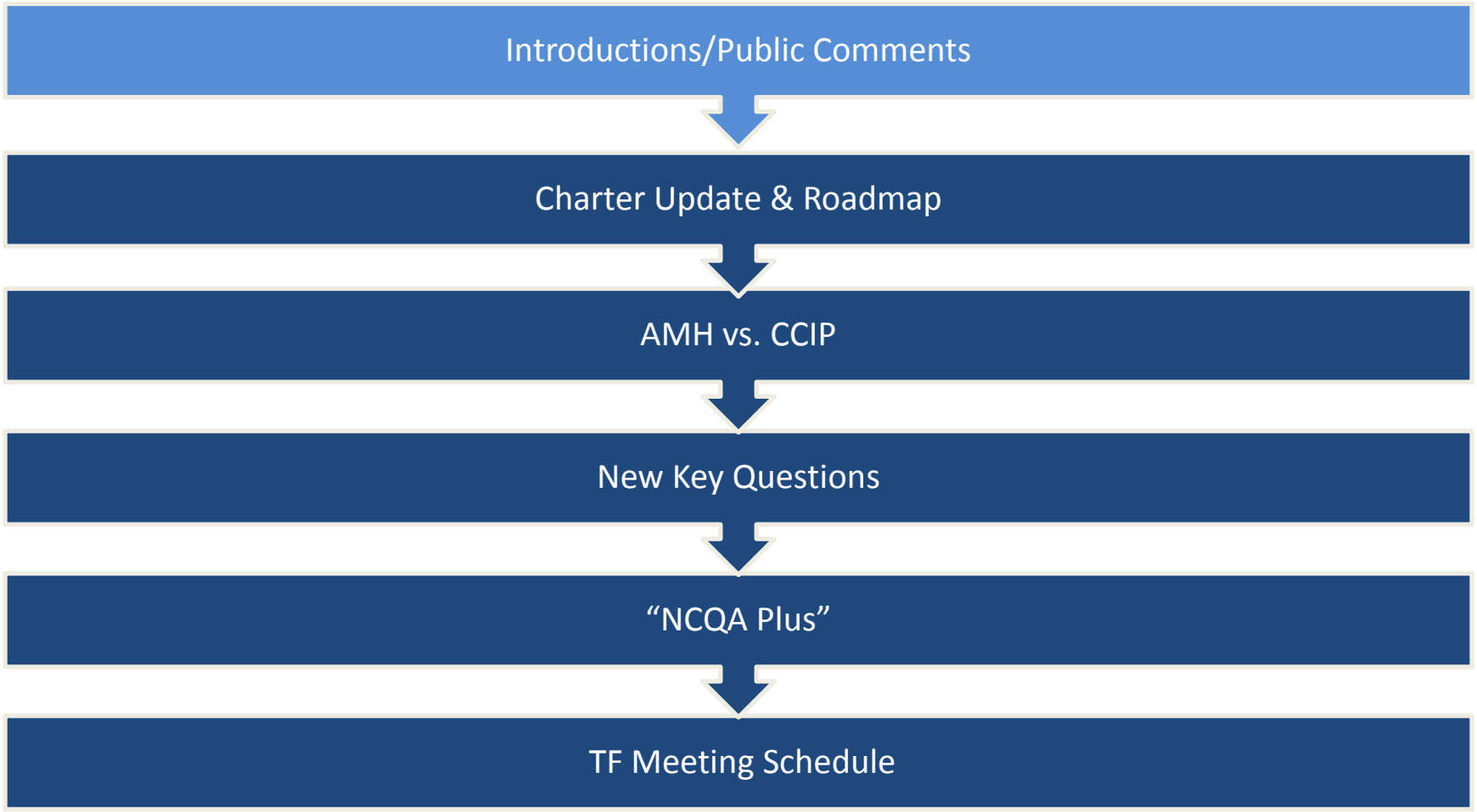
Practice Transformation Taskforce Meeting

September 9th, 2014

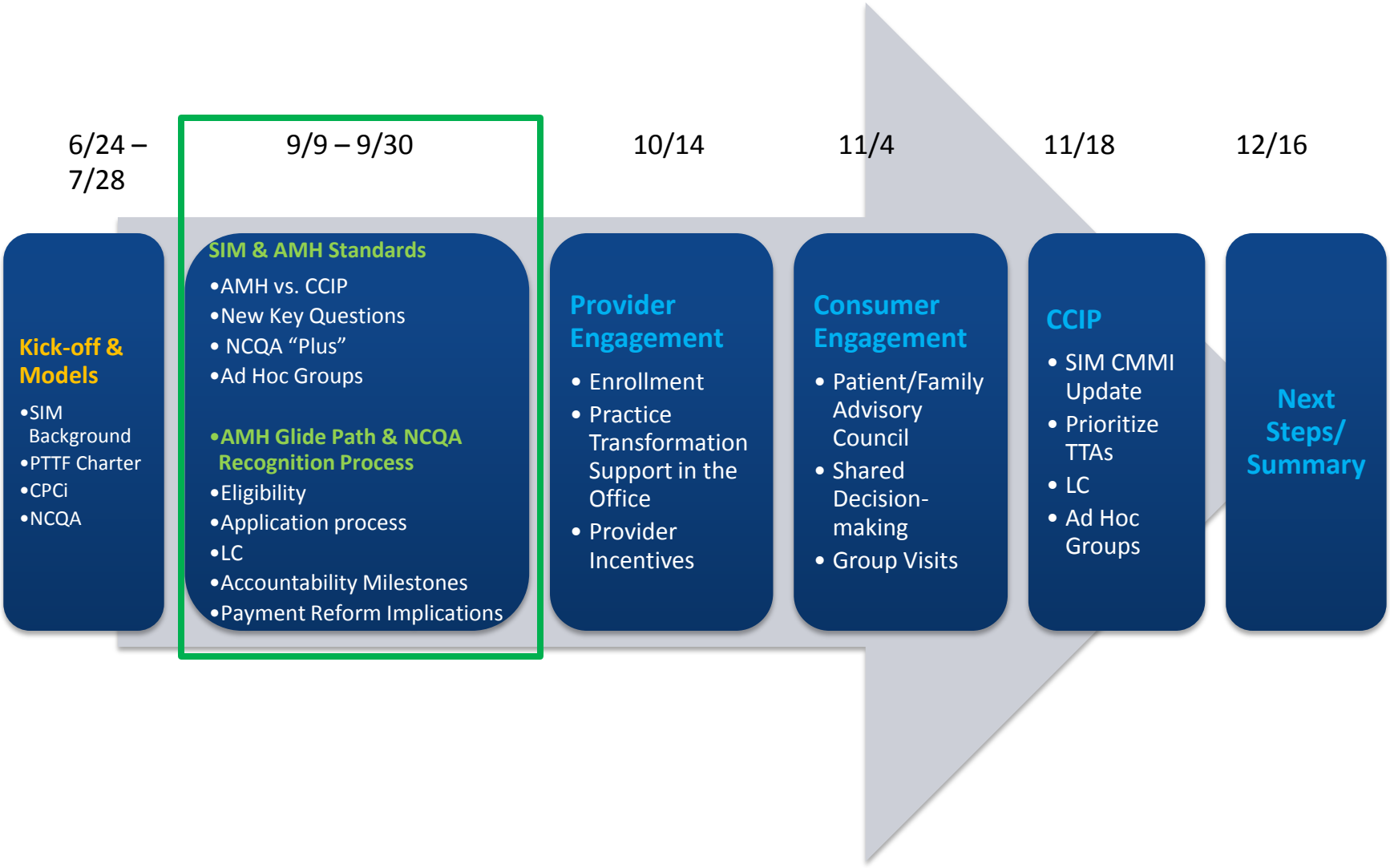
Agenda


Introductions/Public Comments
Charter Update & Roadmap
AMH vs. CCIP
New Key Questions
“NCQA Plus”
TF Meeting Schedule

Proposed Update to the Practice Transformation Charter

- This Task Force **will develop for recommendation to the Healthcare Innovation Steering Committee**, a proposal for the implementation of the Advanced Medical Home (AMH) model under the Connecticut Healthcare Innovation Plan (SHIP).
- The AMH Model has five core components:
  - (1) Whole-person-centered care
  - (2) Enhanced access
  - (3) Population health management
  - (4) Team-based coordinated care
  - (5) Evidence-informed clinical decision making
- This work group will develop a recommendation for the **advanced medical home (AMH) standards**, detail the design of a **"glide path" program** in which providers are offered practice transformation support services for a limited period of time, advise on the process for **vendor selection** for practice transformation support and practice certification, and coordinate with interdependent workgroups and initiatives.
- This work group will develop a recommendation for the build of the Community and Clinical Integration (CCI) and Innovation Awards (IA) programs.
- The Task Force will identify **key stakeholder groups** whose input is essential to various aspects of the Task Force's work and formulate a plan for engaging these groups to provide for necessary input.
- The Task Force will convene **ad hoc design teams** to resolve technical issues that arise in its work.

Practice Transformation Roadmap



CT AMH + Community and Clinical Integration Program(CCIP)

NCQA 2014 Standards

1. Patient Centered Access
2. Team-Based Care
3. Populations Health Management
4. Care Management and Support
5. Care Coordination and Care Transitions
6. Performance Measures and Quality Improvement

Targeted Technical Assistance

1. Integrate behavioral health
2. Integrate oral health
3. Medication management
4. Build dynamic clinical teams
5. E-Consults (PCPs and Specialists)
6. Community health workers
7. Close health equity gaps
8. Care experience with vulnerable populations
9. Community linkages and integration
10. Super-utilizers/"Hot-spotters"
11. Quality Improvement Analytics/Reports*

***Additional TTA FQHC Only**

AMH Key Questions

Advanced Medical Home (AMH) Standards

1. Are NCQA 2014 standards sufficient as is to meet the CT AMH vision?
2. Are there 2014 NCQA standards that should be changed from “optional” to “must pass”?
3. What additional or supplementary standards, elements or factors need to be built for CT AMH? Should they be built out NCQA standards or CT-made standards?
   - What additional verification/recognition process is needed for these new standards?
4. Do we need to differentiate between pediatric standards and adult standards? How?
5. What is the appropriate recognition for a practice that has achieved CT AMH standards?

Advanced Medical Home (AMH) Glide Path

6. How will providers be engaged?
   - What is the motivation for a practice to be engaged in practice transformation?
7. How will consumers be engaged?
   - How will we ensure the patient voice is incorporated?
8. What milestones can be incorporated to assure that practices show practice transformation over time?
9. Who is eligible to participate?
10. What are the LC implementation considerations – format? delivery schedule? level of participation?
11. What are the implications on payment?

“NCQA Plus” Discussion – Sept 9 and 30, 2014

Objective: **Answer AMH Standards Questions 1-3**

- Review and evaluate current NCQA 2014 standards to decide:

1. Are NCQA 2014 standards sufficient “as is”?
2. Should any elements change to “must pass”?
3. Do we need to build any additional elements, factors or standards?
4. How we will verify that transformation has occurred?

Example Standard X:

NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification
No changes necessary --Or-- Not sufficient "as is" recommend additional criteria because x, y, z…	Element C should be changed to must pass as opposed to optional because it is a crucial aspect of our AMH strategy…	Standard X is very superficial we want more depth. Need a new offshoot Standard Y that will focus on these specific details/components of X.	To validate that transformation occurred for Standard X we will need an onsite team to track and view changes…

Standard 1: Patient-Centered Access

- A) Patient-Centered Appointment Access (MUST PASS)
- B) 24/7 Access to Clinical Advice
- C) Electronic Access

NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification

Standard 2: Team Based Care

- A) Continuity
- B) Medical Home Responsibility
- C) Cultural and Linguistic Appropriateness Standards (CLAS)
- D) The Practice Team (MUST PASS)

NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification

Standard 3: Population Health Management

- A) Patient Information
- B) Clinical Data
- C) Comprehensive Health Assessment
- D) Use Data for Population Management (MUST PASS)
- E) Implement Evidence-Based Decision Support

NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification

Standard 4: Care Management and Support

- A) Identify Patients for Care Management
- B) Care Planning and Self-Care Support (MUST PASS)
- C) Medication Management
- D) Use Electronic Prescribing
- E) Support Self-Care and Shared Decision Making

NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification

Standard 5: Care Coordination and Care Transitions

- A) Test Tracking and Follow-Up
- B) Referral Tracking and Follow-Up (MUST PASS)
- C) Coordinate Care Transitions

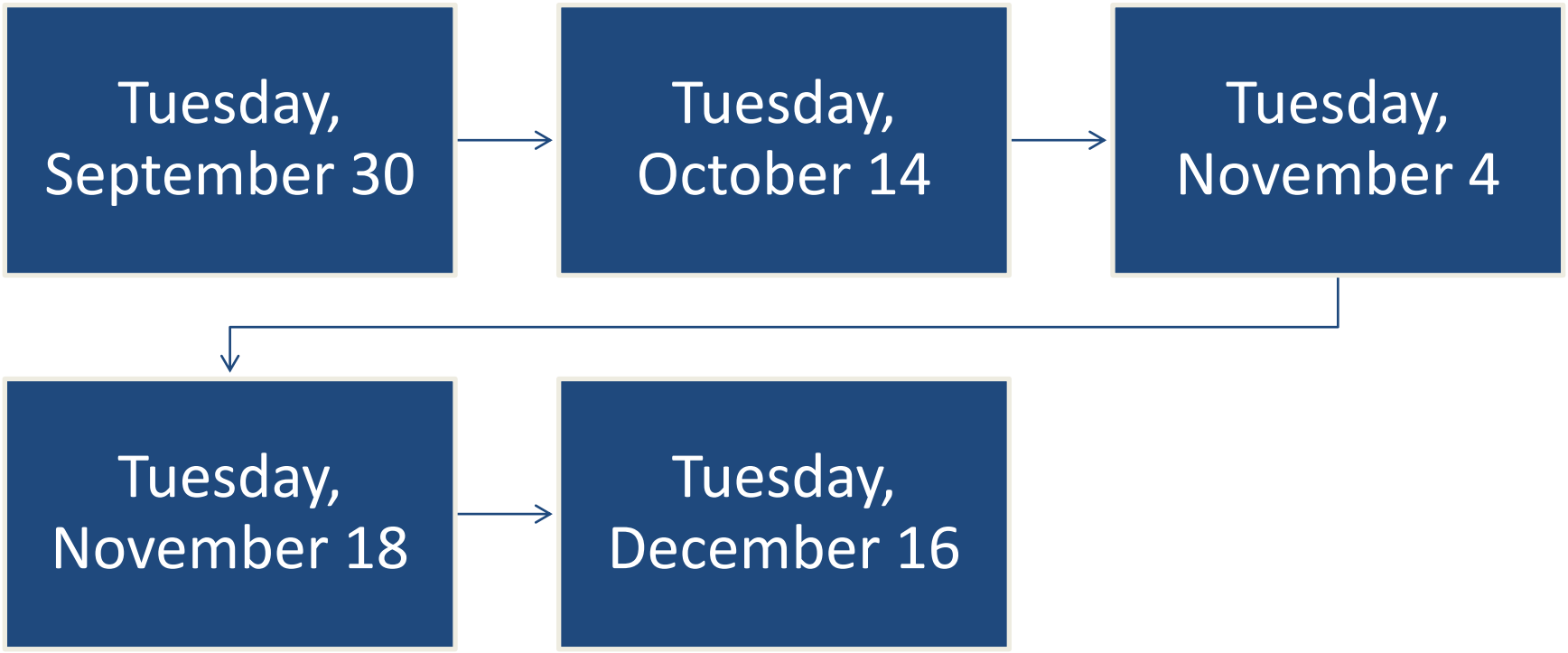
NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification

Standard 6: Performance Measurement & Quality Improvement

- A) Measure Clinical Quality Performance
- B) Measure Resource Use and Care Coordination
- C) Measure Patient/Family Experience
- D) Implement Continuous Quality Improvement (MUST PASS)
- E) Demonstrate Continuous Quality Improvement
- F) Report Performance
- G) Use Certified HER Technology

NCQA 2014 "As Is"	NCQA "Must Pass"	NCQA New Element/Standard	CT AMH Transformation Verification

Meeting Schedule



Appendix

Community and Clinical Integration Program (CCIP) Description

- **Community and Clinical Integration Program (CCIP):** The CCIP will offer Targeted Technical Assistance and Innovation Awards to Advanced Networks and FQHCs, selected to participate in Medicaid QISSP. CCIP will accelerate advancement and spur investment in transformation. The PMO will contract with vendors to provide the Targeted Technical Assistance on the 11 focus areas.
- The PMO will establish two **Learning Collaboratives (LCs)** to support providers participating in the CCIP. The first LC will be tailored to the needs of FQHCs and the second will be tailored to Advanced Networks. The LCs will foster continuous learning through webinars, workshops, an online collaboration site, and phone support. Participants will be expected to actively share resources, tools, and strategies with each other in the LC. LC participants will report quarterly progress on achieving milestones to track transformation.
- The PMO will offer **Innovation Awards** to competitively selected providers participating in the CCIP. Innovation awards will support transformational demonstration pilots that align with CCIP priorities. The PMO will establish an Innovation Awards advisory committee to establish award criteria and processes.

Patient-Centered Medical Home 2014

(6 standards/27 elements)

1) **Patient-Centered Access (10)**
   - A) ***Patient-Centered Appointment Access (4.5)**
   - B) 24/7 Access to Clinical Advice (3.5)
   - C) Electronic Access (2)
2) **Team-Based Care (12)**
   - A) Continuity (3)
   - B) Medical Home Responsibilities (2.5)
   - C) Culturally and Linguistically Appropriate Services (2.5)
   - D) ***The Practice Team (4)**
3) **Population Health Management (20)**
   - A) Patient Information (3)
   - B) Clinical Data (4)
   - C) Comprehensive Health Assessment (4)
   - D) ***Use Data for Population Management (5)**
   - E) Implement Evidence-Based Decision Support (4)
4) **Care Management and Support (20)**
   - A) Identify Patients for Care Management (4)
   - B) ***Care Planning and Self-Care Support (4)**
   - C) Medication Management (4)
   - D) Use Electronic Prescribing (3)
   - E) Support Self-Care and Shared Decision Making (5)
5) **Care Coordination and Care Transitions (18)**
   - A) Test Tracking and Follow-Up (6)
   - B) ***Referral Tracking and Follow-Up (6)**
   - C) Coordinate Care Transitions (6)
6) **Performance Measurement and Quality Improvement (20)**
   - A) Measure Clinical Quality Performance (3)
   - B) Measure Resource Use and Care Coordination (3)
   - C) Measure Patient/Family Experience (4)
   - D) ***Implement Continuous Quality Improvement (4)**
   - E) Demonstrate Continuous Quality Improvement (3)
   - F) Report Performance (3)
   - G) Use Certified EHR Technology (0)

***Indicates Must Pass Element**